STAFF/VOLUNTEER HEALTH HISTORY

Staff Member's/Volunteer's Name: _____

The following information is required:

Emergency Contact Person: _____ Phone: _____

Primary Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

2. Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

IMMUNIZATION INFORMATION:

For staff members/volunteers who reside **within** the United States, a United States territory, or the District of Columbia:

1. State/territory in which person resides: _____
2. Is this person exempt from any immunizations? [ ] NO
   [ ] YES, List them: _____

OR

For staff members/volunteers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. Country in which person resides: _____
2. Attach Department form DHMH-896 (record of vaccination or immunity)

_____

Staff Member/Volunteer Signature or Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years)

Date